Commonwealth of Massachusetts
GROUP INSURANCE COMMISSION

Framing the Debate

on Health Care Costs and Quality

Fiscal Year 2009
Annual Report

Commonwealth of Massachusetts
Group Insurance Commission
Your Benefits Connection

THE GROUP INSURANCE COMMISSION

The mission of the Group Insurance Commission is to provide high value health insurance and other benefits to state employees, retirees, and their survivors and dependents as well as to housing and certain other authorities. The GIC also provides health-only benefits to participating municipalities' employees, retirees, and their survivors and dependents. The agency works with vendors selected through competitive bidding to offer cost-effective services through careful plan design and rigorous ongoing management. The agency's performance goals are providing affordable, high quality benefits, and as the largest employer purchaser of health insurance in the Commonwealth, using that position to help drive improvements in the entire health care delivery system.

The GIC offers the following benefit programs:

- A diverse array of health insurance options
- Term life insurance
- Long Term Disability (LTD) insurance
- Dental/Vision coverage for managers, legislators, legislative staff and certain Executive Branch employees
- Dental coverage for retirees
- Discount vision plan for retirees
- Health Care Spending Account (HCSA)
- Dependent Care Assistance Program (DCAP)

COMMONWEALTH OF MASSACHUSETTS
GROUP INSURANCE COMMISSION
Fiscal Year 2009 Annual Report
Editor: Cynthia E. McGrath

Design and Printing: Red Sun Press
Printed on Recycled Paper
Printed January 2010

Dear Friends:

Throughout Fiscal Year 2009, the GIC was in the forefront of efforts to frame the debate on how best to control rising health care costs while improving quality. The GIC's Clinical Performance Improvement (CPI) Initiative continued its groundbreaking work — analyzing differences in provider efficiency and quality and giving members incentives through lower copays to see better performing providers. The program has helped spark debate in the health care community about the role providers must play in improving quality and cutting the overuse of resources.

Municipalities, like employers everywhere, were also struggling with soaring health insurance costs. The Municipal Partnership Act, signed into law as part of the Acts of 2007, allows municipalities to join the GIC's pool for health insurance benefits. Throughout FY09, the GIC worked diligently to help municipalities evaluate the option and enrolled 14 additional cities, towns and school districts, which very likely will save these municipalities millions of dollars.

With the Commonwealth facing austere budget times, how does the GIC best constrain its own substantial budget? Difficult decisions, including benefit reductions, were made in FY09 to help reduce the GIC's projected expenditures. Communicating, communicating, and communicating again helped us make these changes effectively and efficiently. And, collaborating with others to develop solutions to rising health care costs and disparities in quality played an even more critical role.

We hope, that as you read this annual report, you will agree that we are not only helping to frame the debate, but also doing the heavy lifting required to improve health care quality and control health care costs for all Massachusetts residents.

Very truly yours,

Dolores L. Mitchell
Executive Director

Why Are Health Care Costs Rising?

HEALTH CARE COSTS CONTINUE TO SKYROCKET.
NATIONALLY:

- Health premiums rose 6.3% in 2008, but only after benefit cutbacks
- Without benefit changes, health premiums would rise on average at least 8% in 2009, according to Mercer Human Resources, a national health care consulting firm

The GIC continued to match or beat these market trends with minimal benefit changes:

- FY09 premium increase 6.37%
- FY08 premium increase 3.75%
- FY07 premium increase 7.3%

But, rising costs and contracting state revenues pose formidable challenges.

Why are the GIC's and other employer and government health care costs rising?

- Prices charged by doctors, hospitals and other providers are going up despite consolidations
- New technology
- Aging population
- Overuse of some services (e.g., radiology and heavily advertised brand drugs)
- Lower cost community hospitals being squeezed – Massachusetts utilization of more expensive teaching hospitals is two and one-half times the national average
- Unhealthy lifestyle choices including increased member weight
- Higher costs do not prove higher quality: Numerous studies, including those conducted by the Institute of Medicine and the RAND Corporation, have shown wide disparities in quality of care.

Who Can Solve This Crisis?

The GIC believes all players in the health care community – payers, providers, health plans, and patients – must be part of the solution. To this end, the GIC's Clinical Performance Improvement (CPI) Initiative, now in its fifth year, seeks to:

- Share responsibility– providers, members, health plans, and the GIC - for reducing costs and improving quality
- Maintain comprehensive benefits and choice
- Emphasize health care quality and safety
- Adopt modest member share increases
- Educate members about provider performance
- Encourage healthy behavior

Under the CPI Initiative, the GIC requires our health plans to provide de-identified claims for their entire book of business to our consultants for aggregation and analysis for each provider's efficiency and quality relative to his or her peers. After this process, the results of the analysis are given to the health plans who then use the information to develop tiered networks in which members are given modest co-pay incentives to use better performing doctors.

★★★Tier 1 (excellent) – lowest copay
★★Tier 2 (good) – middle copay
★Tier 3 (standard) – highest copay

In FY09, the following advances were made in the CPI Initiative:

- 142 million de-identified health claims were analyzed.
- An advanced statistical model developed by a leading biostatistician and provost at Johns Hopkins University. was put into production for FY10 tier development. The model takes into account the variation in physician performance and patient compliance.
- A hurdle approach was implemented to emphasize the importance of quality – providers must pass national quality measurements before they are measured on efficiency for tiering purposes.
- In general, approximately 20% of physicians earned a Tier 1 rating, 65% were in Tier 2 and 15% were in Tier 3.
- The reporting of tiering details to physicians was improved and defined periods for feedback were established.
- Two new core specialties for tiering were adopted by all employee health plans for FY10: Pulmonology/Pulmonary Disease and ENT/Otolaryngology.

The GIC was one of the first employers to adopt physician tiering as a means to improve health care quality while reducing costs. This approach began to be adopted by other purchasers and providers of health insurance during FY09. Examples include the Minnesota State Employee Group Advantage Health Plan, which gives physician copay incentives to members who complete a health risk assessment and see more cost efficient physicians. Blue Cross Blue Shield of Massachusetts Network Blue Options tiers Primary Care Physicians based on the plan's quality and cost benchmarks. Aetna Aexcel® tiers 12 medical specialties according to the plan's clinical performance and efficiency standards.

What Is The GIC's Role In Solving The State's Budget Crisis?

The state was facing a severe fiscal crisis throughout the fiscal year: a $2 billion state revenue shortfall was projected for FY10 as of the middle of the FY09 fiscal year and the outlook for upcoming fiscal years remained uncertain. Revenues plummeted and budget cuts were necessary across all Commonwealth programs and services. With an original FY09 appropriation of $1.4 billion, the GIC's main premium account is a large line item in the state's budget, even though 34% of it was returned in this fiscal year to the General Fund in reimbursements by offline agencies and municipalities.

To help close the state's budget gap, the Governor exercised his "9C" constitutional authority and cut $32 million from the GIC's health premium account, with a recommendation to tier state employees' premium contributions based on salary. The legislature did not enact the salary-based legislation and, with no time to make up the shortfall through benefit cuts, a supplemental budget was needed to close the gap. However, the GIC understood it needed to make changes in order to mitigate expected FY10 expenditures of $1.6 billion caused by increased utilization and a 10% increase in enrollment from municipalities joining the GIC.

To bring the GIC's FY10 budget in line, the GIC has negotiated level administrative budgets across all health plans and a very low weighted premium increase of 3.19% with the following benefit changes:

- Prescription drug copays increased and standardized across all plans
- Increased specialist office visits by $5 for each tier for most plans; small increase in Primary Care Physician copays for some plans
- Increased copays and tiered structure for inpatient hospital copays for the self-insured plans – Harvard Pilgrim Independence Plan, Navigator by Tufts Health Plan and UniCare State Indemnity Plan/PLUS
- Introduction of high-tech imaging (e.g., MRI, CT and PET scans) copay
- Emergency room copay standardized
- Increased or introduction of tiered outpatient surgery copays – Harvard Pilgrim Independence Plan, Navigator by Tufts Health Plan and UniCare/PLUS

How Can The GIC Help Municipalities, Their Workers, And Massachusetts Taxpayers With Rising Health Care Costs?

Recognizing that health care costs were posing a formidable challenge to municipalities and their ability to maintain services, the legislature passed the GIC Municipal Partnership Act – Chapter 67 of the Acts of 2007 that was signed into law by the Governor in July of 2007. During FY08, the GIC put in place the necessary infrastructure to begin adding municipal enrollees: system changes, new forms, procedural changes and training programs. Ten municipalities, planning councils, and school districts joined the GIC effective July 1, 2008, and more were expected for the following July with municipalities using the additional time to evaluate the option. Throughout FY09, without additional resources, the GIC provided helpful information to new municipalities:

- The GIC participated in the Lieutenant Governor's listening tours, held across the state, to describe the program and to answer questions
- A municipal brochure was developed to help municipalities weigh the GIC option and give information on how to calculate the savings they might realize by joining the GIC
- A municipal resource center was added to the GIC's website, providing comprehensive information on the GIC health insurance option
- Staff participated in the Mass Municipal Association trade show, fielded phone and email inquiries, and provided presentations across the state to Public Employee Committees

December 1, 2008 was the deadline for municipalities to file their agreement to join the GIC for July 1, 2009 and the following communities opted to join the GIC:

City of Melrose • City of Quincy • City of Pittsfield • Town of Norwood • Town of Randolph
Town of Stoneham • Town of Swampscott • Town of Watertown • Town of Wenham
Town of Weston • Town of Weymouth • Blue Hills Regional School District
Groton-Dunstable Regional School District • Pioneer Valley Planning Commission

To make a smooth transition, numerous in-person and teleconference training sessions were held. A new software application was developed that allowed municipalities to input their enrollment data in the same format, eliminating the need for subsequent edits and helping to ensure that all information was included. The GIC worked with municipalities to get the word out to their employees and retirees about the documents they would need for eligibility purposes to join the GIC. All new forms and procedures were produced to account for the health-only option for municipalities. Health fairs were scheduled near to where new municipalities were joining and a special *Benefit Decision Guide* was developed to help municipal employees and retirees with evaluating their options.

The bottom line – over 13,200 new members were enrolled effective July 1, 2009, and the municipalities reported substantial savings for the fiscal year as the result of joining the GIC.

The bottom line – over 13,200 new members were enrolled effective July 1, 2009, and the municipalities reported substantial savings for the fiscal year as the result of joining the GIC.

These savings were calculated on the municipalities' current rates and enrollment, including premium increases anticipated from the municipalities' carriers prior to joining the state's health insurance program:

- City of Quincy $10 million
- Town of Watertown $2.6 million
- Town of Randolph $2 million
- City of Pittsfield $2.6 million
- Town of Norwood $1.5 million

Anecdotal evidence suggests that several municipalities that did not elect to join the GIC also realized savings, negotiating better rates through their current health insurance carriers, possibly due to the competition provided by the GIC option.

How Do We Influence Change At The Local And National Level?

Changes do not take place in a vacuum, and it will take many people working together to make much needed improvements in the health care system. Throughout FY09, the GIC was at the forefront of health care policy activism, collaborating and cooperating with multiple state agencies, national health quality organizations and private sector groups in the achievement of common objectives:

- Health Care Quality and Cost Council: The GIC's Executive Director is an ex officio member of this group established by the legislature to provide public information about health care quality and costs.
- National Committee for Quality Assurance (NCQA): The GIC's Executive Director serves on the Board of this national accrediting organization. All of the GIC's managed care plans have been required for many years to be accredited by NCQA.
- Massachusetts Prescription Reform Coalition: The GIC continued its involvement with this organization, which is committed to addressing the high costs of prescription drugs. The organization successfully advocated for the passage of a state law limiting gifts and payments to prescribers by the pharmaceutical and medical device industries, and commented on the proposed regulations implementing the law.
- Massachusetts Health Connector Authority: The GIC's Executive Director continued to serve as a Board member of the Connector Authority, charged with implementing the Massachusetts Health Care Reform legislation. Major strides were made during FY09 to ensure that Massachusetts residents have health insurance at affordable costs.
- Payment Reform Commission: The Executive Director served as a member of the Payment Reform Commission, charged with developing proposals to change provider reimbursements in an effort to improve quality and control costs.
- Serious Reportable Events Taskforce: As part of the Healthy Mass Compact, the taskforce, in cooperation with the Mass Department of Public Health, finalized a complementary set of guidelines and regulations that will assure that the 28 adverse events are properly reported, followed up, appropriate parties, including the patient, notified and, if the hospital was at fault, the facility not reimbursed.
- Transition Taskforce: The GIC is one of over 140 participants who are working to improve the movement and coordination of patients between types of facilities and levels of care with a goal of preventing unnecessary readmissions.
- Interagency Analytic Workgroup: This group is working to increase the coordination of data analytic projects in the Commonwealth.
- All Payer Claims Data Set Development Group: This group is developing specifications for a Massachusetts all-payer database with a goal of implementation in 2011.
- Healthy Massachusetts Disease Management and Wellness Task Force: The GIC participated in the diabetes sub-task force, comprised of state agencies and specialists/organizations across the Commonwealth, focused on developing a framework for both the prevention and management of diabetes in Massachusetts. Their published report, in June 2009, outlined six recommendations to improve outcomes, quality of care and cost control.
- Hospital Quality Alliance (HQA): In FY09, the GIC's Executive Director was appointed to this national organization, comprised of hospital organizations and consumers devoted to improving health care quality in the hospital setting.
- Institute for Clinical and Economic Review (ICER): The GIC participated in meetings by this group with focuses on providing studies of clinical benefit and economic value of treatment options.
- Partnership for Healthcare Excellence: The GIC continued to collaborate with this group, dedicated to improving patient education, consumer-advocacy and action in the health care arena for Massachusetts residents, providing GIC members with their clinically-approved education materials in our newsletter and on our website.

- "Heroes in Health Care" Boston Visiting Nurses Association award: The GIC's Executive Director, Dolores Mitchell, received recognition for her work in advancing health care quality, safety, and affordability, when the Boston VNA bestowed on her this award in March of 2009. The VNA stated, "Dolores Mitchell has demonstrated unwavering commitment to the health and well being of the greater Boston community."

As in years past, the GIC remained active in the Coalition for the Prevention of Medical Errors, the Massachusetts Health Data Consortium, the New England Employee Benefits Council, the Massachusetts Compassionate Care Coalition, and the Associated Industries of Massachusetts (AIM) Health Care Committee.

How Do We Improve What We Do Without Added Costs?

GIC Regulations

The GIC's regulations, last updated in 1996, were due for an overhaul to reflect new laws and administrative challenges that had become effective since the last iteration. The GIC Counsel, in cooperation with staff from Operations and other departments, drafted new regulations that are easier to understand and use. They give the GIC flexibility to issue administrative bulletins to clarify our policies and procedures. Other changes included new provisions needed as a result of the Municipal Partnership Act, anti-fraud provisions, and clarification of current programs. After a public hearing and the public comment period, final regulations were prepared and approved for promulgation by the Secretary of State.

FSA Carrier Procurement

With out-of-pocket health care costs rising, the Health Care Spending Account (HCSA), one of the two GIC pre-tax programs, offers employees a way to offset these costs by saving on federal and state taxes. The contract with SHPS, the plan administrator for HCSA and the Dependent Care Assistance Program, was set to expire on December 31, 2009, and the GIC went out to bid for a carrier during FY09. After a rigorous procurement, the GIC selected Benefit Strategies of Manchester, New Hampshire as its new carrier.

As a result of this selection, state employees received the following enhancements:

- A reduced monthly fee of 4%
- An increased maximum HCSA election
- If the employee re-enrolls for 2010, claims will be applied to the employee's remaining 2009 balance before deductions will be taken from their 2010 account.

As a result of this selection, state employees received the following enhancements:

- A reduced monthly fee of 4%
- An increased maximum HCSA election
- If the employee re-enrolls for 2010, claims will be applied to the employee's remaining 2009 balance before deductions will be taken from their 2010 account.

Optional Life Insurance Family Status Change

Recognizing that a family's life insurance needs change as the result of a change in family status, the GIC implemented an enhancement to its optional life insurance program effective October 1, 2008. If an employee has a qualified family status change, he or she may enroll in or increase their optional life insurance coverage without any medical review in an amount up to four times their salary within 31 days of the qualifying event. Qualifying family status changes include the following events:

- Marriage
- Birth or adoption of a child
- Divorce
- Death of a spouse

MAGIC Upgrade

The GIC's critical eligibility, enrollment, change and reporting legacy system (MAGIC) has served the GIC, its vendors and agency Coordinators well over many years. But, as new laws have passed, and new groups of enrollees have become eligible for GIC benefits, it has become more difficult to modify the system to meet all of the GIC's business process needs. To keep costs low and maintain the core functionality of the existing system, the GIC proceeded with a phased project to upgrade the system. The main objective is to modernize the infrastructure and functionality of this system while attaining the following goals:

- Integrate all programs and systems maintained by the GIC
- Provide ad hoc query and reporting tools
- Streamline application processes with a user-friendly look and interface
- Implement browser-based access for internal and external customers
- Provide a flexible infrastructure that allows the MAGIC system to keep pace with new functionality and technology
- Ability to move applications to the local environment without time-consuming programming.

During FY09, the GIC reviewed and outlined all of its business processes and prioritized the most critical tasks for the enhanced system.

Medicare Part D

The GIC continued to participate in the federal subsidy program for employers that offer prescription drug benefits for their Medicare retirees. The program requires data sharing between the GIC, the Centers for Medicare and Medicaid Services (CMS), three of our Medicare HMO health plans, and the pharmacy benefit manager for the Medicare indemnity plan. To date for FY09, CMS sent $21.5 million to the Commonwealth's General Fund as a result of these efforts. Since program inception in FY06, $75.6 million has been paid to the state's General Fund. During the fiscal year, the agency was audited by CMS on its actuarial assumptions for the subsidy and passed the auditor's review.

Since program inception in FY06, $75.6 million has been paid to the state's General Fund.

Plan Audits

During the fiscal year, the GIC's consultant, Mercer Health & Benefits, conducted follow up audits with UniCare and Express Scripts, the GIC's pharmacy benefit manager. The prior year's audit of UniCare had resulted in recommendations in the areas of claims payment errors, claims system accuracy and quality of correspondence. The re-audit showed that UniCare exceeded financial accuracy and non-payment accuracy goals, but did not meet overall accuracy or payment incidence goals. The GIC is continuing to monitor UniCare's payment incidence accuracy and will re-audit as appropriate. On the whole, the Express Scripts audit results were good. Although the audit did find that Express Scripts had not implemented changes in pricing for specialty drugs, the GIC received in FY10 a half million dollar credit on its invoice for this uncovered error. Further audit work to reconcile the specialty drug co-pay errors is being conducted at Express Scripts' expense.

COBRA ARRA Subsidy

As part of the American Recovery and Reinvestment Act (ARRA), the federal government began subsidizing COBRA rates for employees who were involuntarily terminated from their jobs between September 1, 2008 and December 31, 2009. GIC staff identified the employees who were affected and put together a comprehensive package of notices and forms for future laid off employees. We also communicated the new option in the newsletter, on the GIC's website, in training sessions, and via email. A total of 220 employees elected this coverage at a cost of $109,000, with the Commonwealth's General Fund receiving the subsidy from the federal government. (The GIC itself does not receive the subsidy.)

Communications

The GIC's communications continued to play a vital role in informing members about their benefit options and providing tools to help them take charge of their health. Communicating the Clinical Performance Improvement (CPI) Initiative and why it matters to members is complex, and the GIC used all available communications to give members updates on this important program: *Benefit Decision Guides*, quarterly *For Your Benefit* newsletters, website, annual enrollment letters, and emails to Coordinators and employees on the state's listserv. Our communications of the CPI Initiative were recognized by the New England Employee Benefits Council and the GIC was presented a "Best Practices of 2008" award in December.

"What do I need to do when I, or my spouse, turn age 65?" is one of the most frequently asked questions the GIC receives. The answers to this question are complex. To help members understand how turning age 65 affects their benefits, we produced a new "Turning Age 65" booklet with large, easy to read type. This brochure is mailed to all retirees turning 65 and to enrollees receiving a pension for the first time. It is also available on our website and is distributed at retiree seminars and at the GIC's health fairs.

Our communications of the Clinical Performance Improvement Initiative were recognized by the New England Employee Benefits Council and the GIC was presented a "Best Practices of 2008" award in December.

During FY09, the GIC collaborated with the Commonwealth's Connector Authority to fold into our communications the Connector option for employees who are laid off or leave state service. Additionally, we enhanced our communication about the Connector option to non-GIC eligible employees covered under the HR/CMS and UMass payroll systems.

Website Portalization

During FY09, the GIC was asked to "portalize" its website, folding the site under Administration and Finance's website umbrella and giving the site the same look and feel as other state agency websites. The GIC collaborated with the Information Technology Division to develop a navigation tree that effectively met our communication objectives and enabled our constituents – members, their dependents, vendors, agency coordinators, municipalities, health policy collaborators and other related agencies – to use the site. New sections, such as step-by-step procedures for Coordinators to administer GIC benefits, as well as putting all communications in ADA-accessible formats were added. more than 360 pages were migrated from the old to the new site and the new site was successfully launched on February 4, 2009.

What Are The Next Challenges And How Do We Prepare For them?

Cost, Cost and Cost

The state's budget crisis coupled with unsustainable health care cost increases will put tremendous pressure on the GIC's ability to continue to provide comprehensive benefits at reasonable costs. At $1.4 billion and growing, the GIC's budget is not an insignificant line item in the state's budget. Utilization of health care services continues to skyrocket. In the meantime, providers are actually raising prices not lowering them, causing increased pressure on the GIC's budget.

The GIC will continue to be a leader in the health care community, determining how best to cut costs without sacrificing quality of benefits. We will continue to push our plans to think creatively about reining in costs to mitigate the impact to our members. And, despite opposition from the provider community, the GIC will continue to lead the way for public reporting on differences in physicians' quality and efficiency.

Other Challenges

County reform legislation calls for sheriffs departments' employees and retirees from the seven counties not already covered by the GIC to join the GIC in FY10. Without much lead time, GIC staff has implemented programming, operations, and communications while collaborating with other agencies to fill in the details for implementation.

The transportation agency reorganization included a complex proposal to consolidate various transportation agencies and move employees and retirees not already covered by the GIC into the GIC. GIC staff members have begun working out the funding provisions, and enroll employees on a staggered basis depending on when their union contracts expire. Sheriffs Departments and transportation agency union employees are understandably wary about the move to the GIC, adding to the challenge. During FY10, GIC staff will work to make the transition as smooth as possible.

With health care costs skyrocketing everywhere, other groups and several quasi-governmental agencies are looking to the GIC as a panacea for covering their employees. If permitted to join the GIC, these additional groups will add pressure to the GIC's budget and its current members' benefits.

With many challenges ahead, the GIC will continue its work to frame the debate on health care quality and costs, working with others to develop innovative solutions to these difficult challenges for the benefit of our members and the taxpayers of the Commonwealth.

Financial and Trend Reports

GROUP INSURANCE COMMISSION
STATEMENT OF EXPENDITURES JULY 1, 2008 - JUNE 30, 2009

DESCRIPTION	COMMONWEALTH	EMPLOYEES
Administration (a)	$2,895,795.00	$0.00
State Employees and Retirees' Basic Life Insurance	$7,858,175.00	$1,819,330.00
State Employees' Optional Life Insurance	$0.00	$24,089,740.00
State Employees' Health Insurance (b)	$1,223,907,509.00	$249,362,606.00
State Employees' Dental And Vision for Managers, Legislators, Legislative Staff and Certain Employees of the Executive Offices	$7,145,966.00	$1,392,687.00
Long Term Disability For State Employees	$0.00	$12,150,456.00
Elderly Governmental Retirees' Health Insurance (c)	$549,641.00	$77,185.00
Retired Municipal Teachers' Life Insurance	$960,758.00	$208,825.00
Retired Municipal Teachers' Health Insurance	$80,446,043.00	$13,403,103.00
Retirees' Dental Insurance	$0.00	$5,817,308.00
Total Expenditures	$1,323,763,887.00	$308,321,240.00

(a) Plus an additional $664,710 from employees' trust funds which were used to pay administrative costs such as postage, telephone and supplies,that are included on the next two statements; and $693,354 from communities participating in the GIC's Health Insurance Programs to cover the additional administrative costs.

(b) Medical and prescription drug co-payments and deductibles for FY09 totaled approximately $117,236,396.

(c) The EGR share includes $19,465 from the EGR Trust Fund and $16,239 from the EGR Rate Stabilization Reserve. These amounts are subsidies to these retirees' premiums.

GROUP INSURANCE COMMISSION
STATEMENT OF REVENUES JULY 1, 2008 - JUNE 30, 2009

SOURCE OF REVENUE	COMMONWEALTH REVENUE
Housing, redevelopment, and other authorities	$74,483,770
Cities, towns, districts and other local governmental units participating in the GIC municipal health program	$76,039,184
Cities, towns and districts participating in the Retired Municipal Teachers' Program and the Elderly Governmental Retirees' Program	$86,570,300
Federal and Trust Fund chargebacks to state agencies	$184,086,663
Charges to state agencies for insureds who are on leave of absence over one year	$575,803
Federal reimbursement subsidy for Medicare Part D Program	$24,649,291
Other income	$1,126,721
Total Revenue credited to Commonwealth's General Fund	$447,531,732

Financial and Trend Reports

SUMMARY OF EXPENSES AND REVENUE COMMONWEALTH SHARE FOR FY09

Total Expenditures	$1,323,763,887
Total Revenue	($447,531,732)
Net Commonwealth Expense	$876,232,155

RATE STABILIZATION RESERVE STATEMENT JULY 1, 2008 - JUNE 30, 2009

RESERVE	BALANCE 7/1/08	RECEIPTS 7/1/08 - 6/30/09	EXPENDITURES 7/1/08 - 6/30/09	BALANCE 6/30/09
Basic Life	$4,587,455.40	$90,610.74	$1,547,494.00	$3,130,572.14
Optional Life	$25,421,921.82	$490,945.89	$1,100,000.00	$24,812,867.71
Employee Health	$72,602.60	$1,464.27	$0.00	$74,066.87
Elderly Governmental Retiree Health	$198,758.22	$3,593.12	$16,239.20	$186,112.14
Retired Municipal Teacher Life	$106,812.76	$2,186.58	$0.00	$108,999.34
Retired Municipal Teacher Health	$28,672.44	$586.98	$0.00	$29,259.42
TOTAL	$30,416,223.24	$589,387.58	$2,663,733.20	$28,341,877.62

EMPLOYEES' TRUST FUND STATEMENTS JULY 1, 2008 - JUNE 30, 2009

	State Employees' Trust Fund	Elderly Governmental Retirees' Trust Fund	Retired Municipal Teachers' Trust Fund
Balance 7/1/08	$4,731,401.72	$201,251.56	$0.19
Receipts	$774,111.74	$3,512.38	$0.00
Expenditures	{$664,710.40}	{$19,464.81}	$0.00
Balance 6/30/09	$4,840,803.06	$185,299.13	$0.19

Financial and Trend Reports

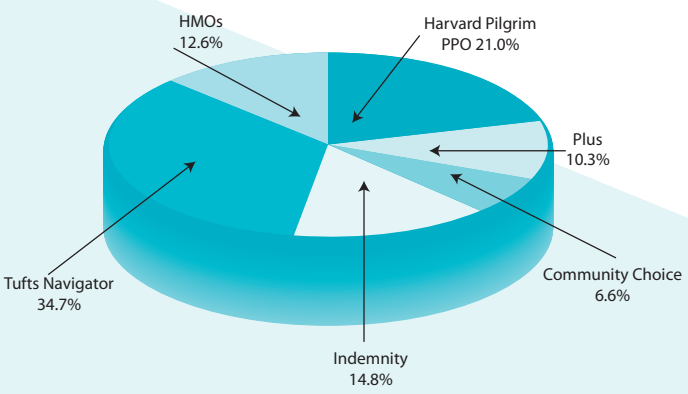
HEALTH PLAN MEMBERSHIP BY INSURED STATUS FY2009

	TOTAL ACTIVE* LIVES	TOTAL RET & SUR	TOTAL EGR & RMT	TOTAL ENROLLEES	TOTAL DEPENDENTS	TOTAL LIVES
UniCare Indemnity Plan	12,888	55,220	11,543	81,497	19,510	101,007
UniCare PLUS	8,940	1,658	0	10,598	13,354	23,952
UniCare Community Choice	5,784	714	0	6,498	7,663	14,161
Fallon Community Health Plan Direct	1,131	107	19	1,268	1,208	2,476
Fallon Community Health Plan Select	2,495	1,128	128	3,821	3,846	7,667
Harvard Pilgrim Health Care	18,344	3,527	38	21,909	28,164	50,073
Health New England	6,323	1,700	225	8,340	8,911	17,251
Neighborhood Health Plan	1,021	50	56	1,168	1,075	2,243
Tufts Health Plan	30,243	6,492	161	36,896	46,030	82,926
Indemnity-Type Plans	12,888	55,220	11,581	81,535	19,510	101,045
Total PPO-Type Plans	63,308	8,581	0	71,889	95,211	167,100
Total HMOs	10,973	6,795	589	18,571	15,040	33,611
TOTAL-ALL	87,169	70,596	12,170	171,995	129,761	301,756
Indemnity Plan % Total	15%	78%	95%	47%	15%	33%
PPO-Type % Total	73%	12%	0%	42%	73%	55%
HMO % Total	12%	10%	5%	11%	12%	11%

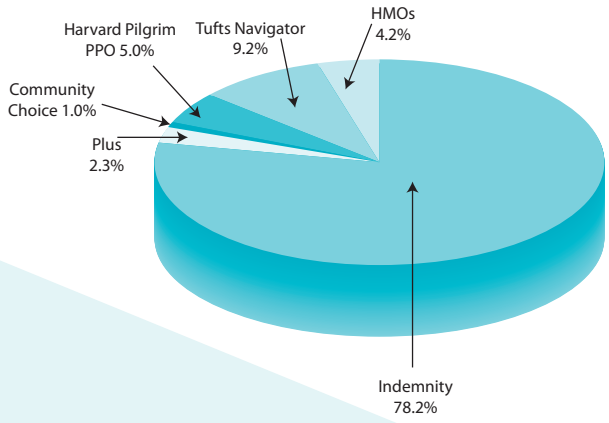
*Active enrollment includes figures for enrollees with IRS and non-IRS dependent coverage.
Source: Pool I Age/Sex Composition Analysis, Fiscal Year 2009 and Pool II Age/Sex Composition Analysis, Fiscal Year 2009

FY 2009 Enrollment

Active Employees by Plan Type - FY 2009



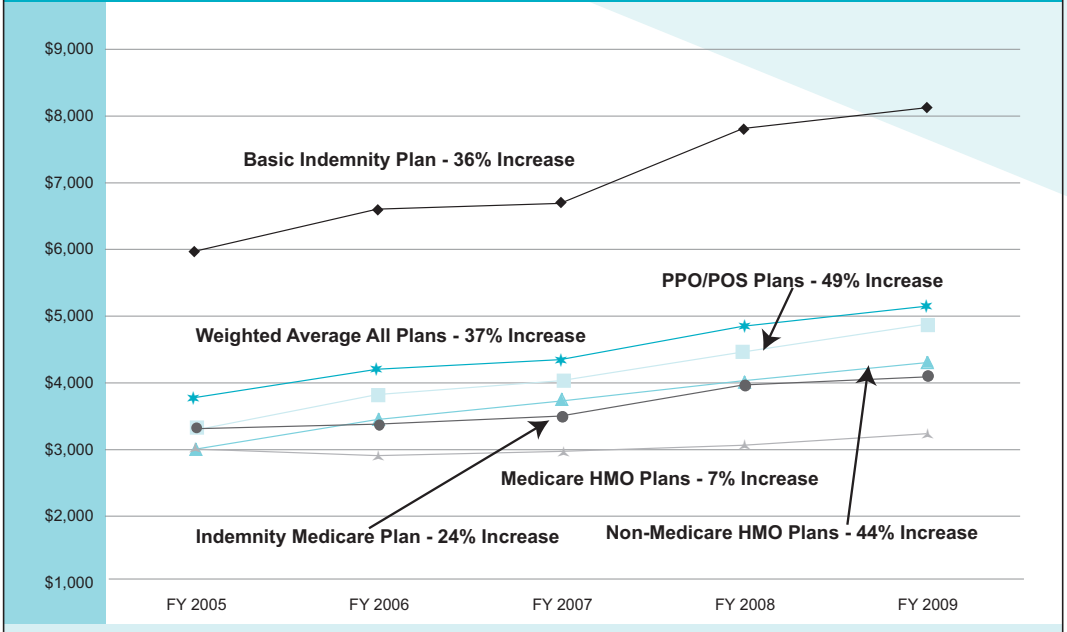
Retirees and Survivors by Plan Type - FY 2009



Source: Pool I Age/Composition Analyis, FY 2009
Does not include EGRs and RMTs

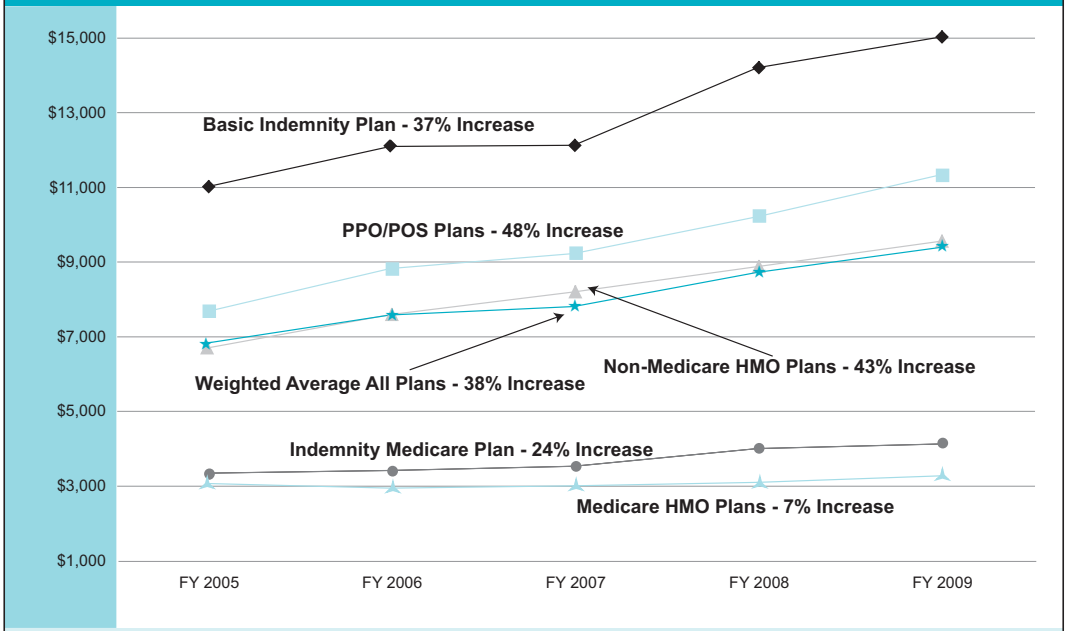
Financial and Trend Reports

COST PER CAPITA*
(Total State and Employee/Retiree Share)



* The PPO/POS Plans include the Indemnity PLUS and Community Choice plans, the HPHC POS/Independence plan, and Tufts Navigator.
** Does not include EGRs, RMTs, or enrollees' out of pocket expenses
Source: Pool 1 Age/Sex Composition Analysis, Fiscal Year 2009.

COST PER SUBSCRIBER (ENROLLEE)*
(Total State and Employee/Retiree Share)



* The PPO/POS Plans include the Indemnity PLUS and Community Choice plans, the HPHC POS/Independence plan, and Tufts Navigator.
** Does not include EGRs, RMTs, or enrollees' out of pocket expenses.
Source: Pool 1 Age/Sex Composition Analysis, Fiscal Year 2009.

COMMONWEALTH OF MASSACHUSETTS
DEVAL PATRICK, Governor
TIMOTHY P. MURRAY, Lieutenant Governor

GROUP INSURANCE COMMISSION
DOLORES L. MITCHELL, Executive Director

COMMISSIONERS
THOMAS A. SHIELDS, Chair
RICHARD E. WARING (NAGE), Vice Chair
SUZANNE BAILEY, *Designee for Joseph G. Murphy, Acting Commissioner of Insurance*
HARRIS A. BERMAN, M.D. (Public Member)
MARY ANN BRADLEY, *Designee for Jay Gonzalez, Secretary of Administration and Finance*
THERON R. BRADLEY (Public Member)
STEPHEN B. CHANDLER (Local 5000, SEIU, NAGE)
DAVID M. CUTLER (Health Economist)
J. MARK ENRIQUEZ (Public Member)
RICHARD J. KELLIHER (Massachusetts Municipal Association)
MARK P. KRITZMAN (Public Member)
ANNE M. PAULSEN (Retiree Member)
PAUL F. TONER (Massachusetts Teachers Association)

Commonwealth of Massachusetts
Group Insurance Commission

19 Staniford Street, PO Box 8747, Boston, MA 02114-8747
617.727.2310 • TDD/TTY 617.227.8583 • www.mass.gov/gic